REQUIREMENTS FOR COMMUNITY SERVICE LICENSE – DENTAL EXAMINERS

Access this form via website at: **www.hawaii.gov/dcca/pvl**

AGE

Be at least 18 years of age.

APPLICATION

Complete the attached application form. Type or print legibly in dark ink and sign application. Applicants are subject to requirements in effect at the time of filing.

- **Failure to provide the requested information will result in this form being returned to you for completion.**

FEES

ATTACH the non-refundable registration fee of $85 for dentists and $55 for dental hygienist made payable to COMMERCE & CONSUMER AFFAIRS.

**Application fee is not refundable.*

Note: *One of the numerous legal requirements that you must meet in order for your new license to issue is the payment of fees as set forth in this application. You may be sent a license certificate before the check you sent us for your required fees clears your bank. If your check is returned to us unpaid, you will have failed to pay the required licensing fee and your license will not be valid, and you* ***may not*** *do business under that license. Also, a $15.00 service fee will be charged for checks which are returned by the bank.*

If for any reason you are denied the license you are applying for, you may be entitled to a hearing as provided by Title 16, Chapter 201, Hawaii Administrative Rules, and/or Chapter 91, Hawaii Revised Statutes. Your written request for a hearing must be directed to the agency that denied your application, and must be made within 60 days of notification that your application for a license has been denied.

DENTAL/ DENTAL HYGIENIST GRADUATE

Be a graduate of a dental/dental hygienist college accredited by the American Dental Association Commission on Dental Accreditation. ***ATTACH*** *a copy of diploma.*

NATIONAL BOARD EXAMINATION

Pass the National Board Dental Examinations Part I & II or National Board Dental Hygiene Examination. **There shall be a 5-year limit of recognition of the National Board exams.** Such time shall be computed from the date the exam is taken to the date of application. ***Arrange*** *to have the final report of the National Board Examination Data Score Card forwarded to the board or attach an original score card to license application.* Copies are not acceptable. Contact the National Board at (312) 440-2678 to request that scores be sent to the Board.

OR

If your examination is beyond the 5-year limit of recognition, make arrangements with the Joint Commission on National Dental Examinations to retake the examination, if applicable.

VERIFICATION OF ACTIVE CLINICAL DENTAL/DENTAL HYGIENE PRACTICE

If applicable, **provide** evidence of active clinical dental/dental hygiene practice of not less than 1,000 hours per year for the 3 years immediately prior to the date of application by having another licensed dentist/dental hygienist complete the attached "Verification of active Clinical Dental/Dental Hygiene Practice" form.

NATIONAL PRACTITIONER DATA BANK VERIFICATION

Applicants who are licensed in a state or U.S. territory are directed to call the Data Bank at 1-800-767-6732 to request a form for self-query or you may download the form from their website at: www.npdb.com. After completing the form, return it directly to the NPDB (not HIPDB). They will send the report to you. You are then to forward the report titled "Search Result-NPDB" to our office.

LICENSE VERIFICATION

Have all jurisdictions where you hold or held a license at any time, complete the attached "*Verification of License*" form. This "*Verification*" form may be duplicated as needed. Allow at least 6 weeks for other jurisdictions to complete the form. Some jurisdictions charge a fee for verification service. Contact the appropriate licensing agency for information on requirements. The applicant is responsible for any fees incurred.

(CONTINUED ON BACK)

EMPLOYMENT

Attach a letter of appointment prepared by your prospective employer giving specific employment dates. Also, have your prospective employer provide documentation of qualifying on a federally qualified health center, Native Hawaiian health systems center, or post-secondary dental auxiliary training program accredited by the American Dental Association Commission on Dental Accreditation.

CONTINUING EDUCATION

Community Service licensees shall actively participate in a formal and ongoing program of clinical quality assurance. It is the responsibility of the licensee to contact the Board's office at (808) 586-3000 to request renewal information.

RENEWAL

All licenses, expire after a year and may be renewed prior to the expiration date on a year to year basis, but not to exceed 5 years.

The failure to timely renew a license, including payment of fees and completion of the continuing education requirement, shall cause the license to be automatically forfeited.

ADDRESS OF BOARD

Mail all required items to:

Board of Dental Examiners
DCCA, P&VL, Lic Br.
P.O. Box 3469
Honolulu, HI 96801

Or

Deliver to office location at:
335 Merchant St., Room 301
Honolulu, HI 96813
Phone: (808) 586-3000

LAWS & RULES PUBLICATION

A copy of the laws, Chapters 447 and 448, Hawaii Revised Statutes, and rules, Chapter 79, Hawaii Administrative Rules, relating to the practice of dentistry may be obtained by submitting a written request to the address above. Chapter 436B, Hawaii Revised Statutes, the Professional and Vocational Licensing Act should be read in conjunction with Chapters 447 and 448 and Chapter 79.

The laws and rules are also posted on our website at: www.hawaii.gov/dcca/pvl. Look under "Dentists and Dental Hygienist".

ABANDONMENT OF APPLICATION

Your application shall be considered abandoned and shall be destroyed if you fail to provide evidence of continued efforts to complete the licensing process for two consecutive years; provided that the failure to provide evidence of continued efforts includes but is not limited to: (1) failure to submit the required documents and other information requested by the licensing authority within two consecutive years from the last date the documents or other information were requested, or (2) failure to provide the licensing authority with any written communication during two consecutive years indicating that you are attempting to complete the licensing process.

This material can be made available for individuals with special needs. Please call the Licensing Branch Manager at (808) 586-3000 to submit your request.

APPLICATION FOR COMMUNITY SERVICE LICENSE– DENTAL EXAMINERS

Follow the instructions and read requirements on the attached sheet.

Name (First-Middle)	(Last)
Residence Address (Include apt. no., city, state & zip code)	
Mailing Address (**ONLY** if different from residence)	
Other names used:	
Social Security No.	Phone No. (days)

FOR OFFICE USE ONLY

Approved	Initials/Date
License No.	*Eff. Date:*
	Exp. Date

Circle Type of License Applying For:

DENTIST DENTAL HYGIENIST

Circle or underline answers; give details when required:

1) Are you at least 18 years of age? ..... YES NO

2) Are you a U.S. citizen, a U.S. national, or an alien authorized to work in the United States? ..... YES NO

3) Have you taken and passed all parts of the National Board exam within the past five years? ..... YES NO

4) a. Do you presently hold a license in any other state? ..... YES NO

b. Where?_____ Date you requested verification to be sent to Board: _____

c. Has any license ever been suspended, revoked or otherwise subject to disciplinary action? ..... YES NO
(If response "yes", explain on separate sheet and arrange to have certified documents from each state in which disciplinary action was taken sent to the Board.)

d. Are there any disciplinary actions pending against you? ..... YES NO
(If response "yes", explain on separate sheet and arrange to have certified documents sent to the Board.)

5) In the past 20 years have you ever been convicted of a crime in which the conviction has not been annulled or expunged? ..... YES NO
(If response "yes", attach court documentation on the date, place, violation of each conviction and fulfillment of conditions of each sentence.)

6) Have you ever had or have pending legal or regulatory action relating to claims of malpractice, or personal or professional misconduct? ..... YES NO
(If response "yes", explain on separate sheet.)

7) Have you actively practiced clinical dentistry/dental hygiene of not less than 1,000 hours per year for the three years immediately prior to the date of application? ..... YES NO
If response "yes", have you requested a "Verification of Active Clinical Dental/Dental Hygiene Practice" form be sent to the Board? YES NO
If "yes", provide date of request: _____.

(CONTINUED ON BACK)

App	168	$50/$20
CRF	169	$35
Service Fee	BCF	$15

APPLICATION FOR COMMUNITY SERVICE – DENTAL EXAMINERS

Name of
Applicant: _____ Date: _____

AFFIDAVIT OF APPLICANT:

I have carefully read the questions in the foregoing application and have answered them truthfully and completely, without reservations of any kind. I hereby authorize educational and other institutions, employers {past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign), to release to the Board of Dental Examiners of the State of Hawaii any information, files or records requested by the board in connection with the processing of this application.

I hereby expressly waive all provisions of law forbidding any physician or other person who has attended or examined me, or who may hereafter attend or examine me, from disclosing any knowledge or information which is thereby acquired, and I hereby consent that any knowledge or information be disclosed to the Board of Dental Examiners in the State of Hawaii.

I understand that misrepresentation is grounds for refusal or subsequent revocation of license (Section 710-1017, Hawaii Revised Statutes).

I also certify that I have read, understand, and agree to comply with the laws and rules that the board determines are required for licensure.

_____ _____

Date Signature of Applicant

This material can be made available for individuals with special needs. Please call the Licensing Branch Manager at (808) 586-3000 to submit your request.

VERIFICATION OF LICENSE – DENTAL EXAMINERS

State of Hawaii
Board of Dental Examiners
P.O. Box 3469
Honolulu, HI 96801

APPLICANT: Complete Applicant section and mail to all jurisdictions where you hold or held a license at anytime. Contact the appropriate licensing agency for information on their processing time and service fees.

APPLICANT

Name (First-Middle)	(LAST)	Social Security No.

Address (Include apt. no., city, state and zip code)

License Number Date Issued

Type of License:

DENTIST DENTAL HYGIENIST

I hereby authorize the licensing agency of _____ to furnish the information below to the State of Hawaii Board of Dental Examiners.

Date _____ SIGN HERE _____

TO BE COMPLETED BY LICENSING AGENCY:

LICENSING AGENCY ONLY

This is to certify that the above-named individual was issued license number _____
to practice as a: [ ] Dentist
[ ] Dental Hygienist

Social Security Number: _____

Date issued: _____

Date license/certificate expires: _____

Has this license/certificate ever been sanctioned in any way (revoked, suspended, surrendered, limited, placed on probation, currently pending disciplinary action, being investigated)?..... [ ] YES [ ] NO
*(Please explain yes response and **attach** copy of board's order and related information.)*

Do your files contain any derogatory information on this applicant?..... [ ] YES [ ] NO
*(Please explain yes response and **attach** copy of board's order and related information.)*

COMMENTS:

Signature: _____

Title: _____ *BOARD SEAL*

State: _____

Date: _____

TO THE APPLICANT: Attach original with board's seal to your application form, or the licensing agency may send directly to the Board.

THIS FORM MAY BE DUPLICATED.

VERIFICATION OF ACTIVE CLINICAL DENTAL/DENTAL HYGIENE PRACTICE

State of Hawaii, Board of Dental Examiners.

Access this form via website via: **www.hawaii.gov/dcca/pvl**

The applicant named below has applied for a community service license with the Board of Dental Examiners. The applicant can qualify for the community service license by passing the appropriate National Board Examination within the last 5 years **or** provide evidence of active practice of clinical dentistry/dental hygiene of not less than 1,000 hours per year for the 3 years immediately prior to the date of application. To verify the active practice of dentistry/dental hygiene, this form shall be completed by a **licensed** dentist or dental hygienist and mailed to: **Board of Dental Examiners, P.O. Box 3469, Honolulu, Hawaii 96801.**

NAME OF APPLICANT:	**VERIFIER IS A LICENSED: _____ DENTIST _____ DENTAL HYGIENIST** **STATE OF LICENSE:** **LIC. NO.:**
PRACTICE VERIFYING: _____ DENTAL	_____ DENTAL HYGIENE
PERIOD VERIFYING: FROM _____ (MONTH/YEAR) TO _____ (MONTH/YEAR)	Total hours verifying:

DESCRIPTION OF DENTAL OR DENTIAL HYGIENE PRACTICE:

I hereby certify that I have personal knowledge of the applicant's active clinical hours of experience, as described above during the 3 years immediately prior to the date of application.

_____
Signature of Verifier

Print Name _____

Address _____

_____

Phone (____) _____

Date _____